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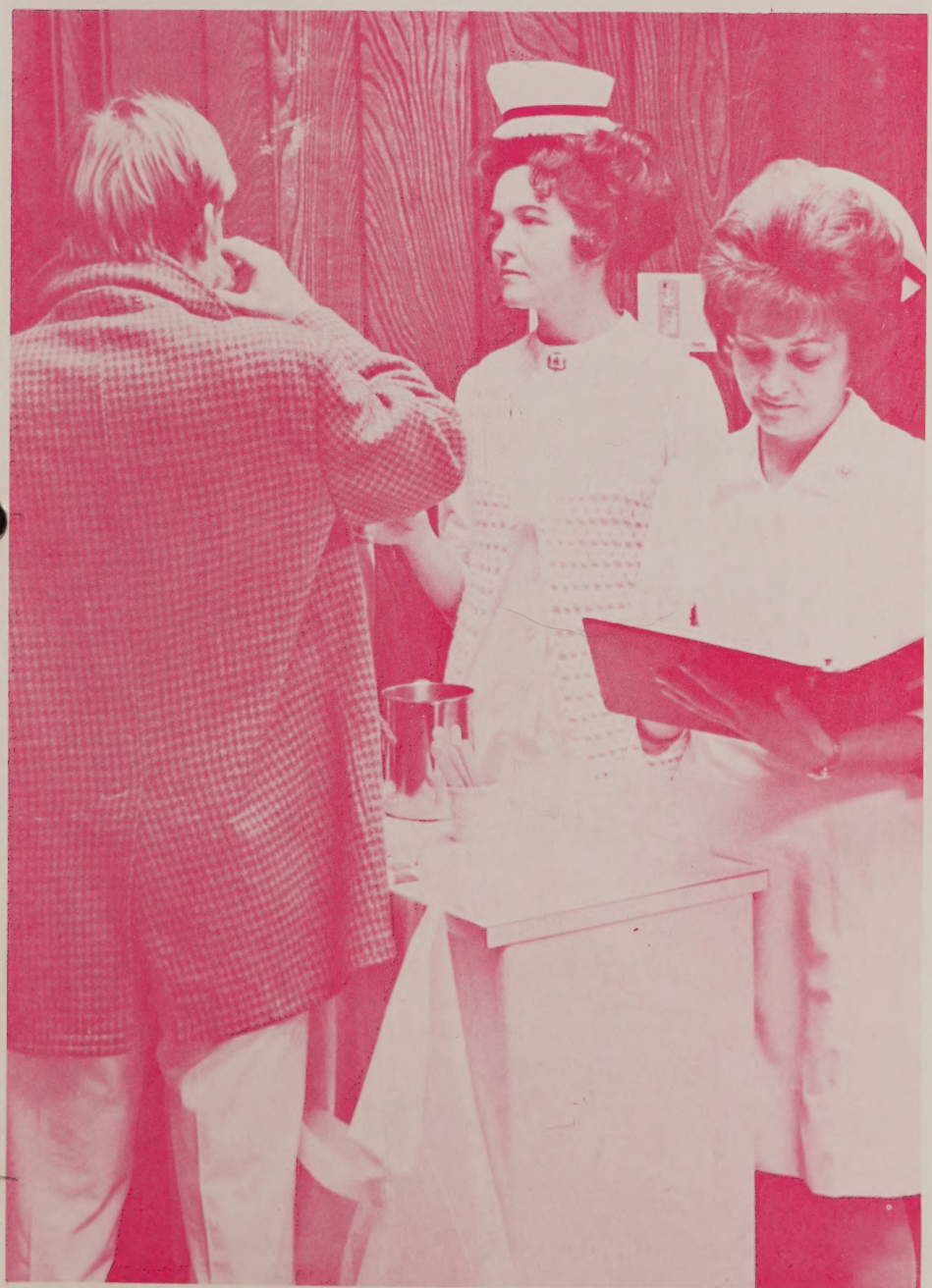

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THE HAMPDEN HIPPOCRAT

A bulletin for
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The Massachusetts
Medical Society

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Editorial . . .

OUR ACHILLES' HEEL

"United we stand; divided we fall!" "In unity there is strength!" These are universally recognized aphorisms which roll off the tongue of every school child because history has proven such to be the case time and time again. We, physicians, have a common bond, namely, the profession of serving humanity by providing skills to heal the sick. This noble dedication has ever been the foundation of approbation and support of physicians by the public. Individually, physicians are still regarded with high favor and respect, but organizationwise, physicians are not faring as well and are becoming increasingly a less potent influence in the evolution of policies pertaining to the so-called health care delivery system of this country. Why is this so? The answer echoing back seems to be *too many internal conflicts.*

At this point, it might be asked what organization indeed represents the physicians or at least the majority of the physicians in this country. Is it the AMA since it claims a membership of 218,882 out of a total of 338,173 physicians as of December, 1970? In spite of this large membership, it would be naive to claim that the AMA represents all of the physicians who belong to it. Some belong because they disagree with the AMA but prefer "to work for reform from within." Others may belong because of certain benefits to be gained from membership which might not be otherwise attainable. Certainly there is a percentage of AMA members who disagree with AMA policy, and this percentage varies from issue to issue. On the other hand, there is a minority of physicians who are definitely outside of the AMA, and they are distributed amongst several organizations – some of which consider themselves to be "activists."

What about the various specialty societies and other groups of associated physicians? Here we uncover a veritable profusion of conflicts wherein general practitioners vie with near specialists (i.e., "some post graduate training with practice mostly confined to" and "board eligible") and specialists (i.e., "board certified"), specialists vie with other specialists (in their own field and other fields because of relative value and/or overlapping of services), academic physicians vie with community based practitioners, self-employed vie with salaried physicians, solo practitioners vie with single and/or mixed group practitioners, etc. One could go on indefinitely and

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give myriads of examples but the end result would still be the same – seemingly endless opportunities for and in fact instances of conflict. Which of these organizations – singly or in concert – can represent our profession?

One would think that there might be some harmony between national organizations and their regional, state, and local constituent organizations. There is even here, to say the best, some ambivalency. Each has its own unique resources, to a greater or lesser extent, which can be brought to bear on an issue and can use differing means to attack same. Such resources include a variety and magnitude of organs of communication, meetings, treasuries, manpower and effective organizational expertise for getting specifics accomplished. This too is conducive to conflict.

From the aforesaid, it is obvious that organized medicine is full of internal conflicts and with a variety of subinterest groups. This is no secret to physicians, but unfortunately it is becoming common knowledge also to those not in the profession who would seek to "reform" medical care in this country. The strategy being considered by the latter is to seek out areas of diversity and exploit same by bargaining to trade-off a little as possible for as much as possible. This is organized medicine's Achilles' heel! This is the approach by which medical care innovators can bring about the changes they believe are in the best interest of the public. This strategy can be by far more effective than depicting organized medicine as an entrepreneurial entity locked in a life and death, rearguard struggle with public interest and attacking same eye-ball to eye-ball. Rather, it would seem more prudent to relegate organized medicine to a state of irrelevancy wherein its opinions are taken seriously on occasion but increasingly ignored with the progress of time, and finally to the point where public acceptance of its goodwill toward public interest is lost. Planned conveyance to irrelevance would lead to less embitterment than outright destruction ensuing a bitter conflict. Piecemeal exploitation by division and diversity with opportunistic enticements and conversions would tend to retain the cooperation of physicians and allied health personnel. Without the latter, no health care system can operate.

It behooves all of us to recognize the strategy being adopted to exploit our one major vulnerability. We must join our hands and prove that organized medicine can and will serve public interest as well as self-interest. What better vehicle can our profession use than the AMA and its constituent state and local societies? Our tried and true organizations must not be sacrificed to the state of irrelevancy and impotency. To quote another trite truism originating from Benjamin Franklin: "We must all hang together or assuredly we shall all hang separately."

Ayres

COVER: Partaking of cranberry juice with methadone at the Providence Hospital's MMTP (See pages 8-11).

THE MEDICAL CREDITS DIVISION

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President's Page

THE THIRD PERIOD

Twentieth Century American medicine fits rather neatly into three periods similar to an ice hockey game. The first third of the 20th Century involved efforts to upgrade the quality of graduate physicians. The second third has distinctly improved specialty training. In the final third of this century we are faced with a different problem, namely, that of solving the adequate provision and distribution of medical care.

By 1893 Johns Hopkins had earned respect in the American medical community for its excellence as a teaching center and for the high quality of medical care available there. From 1900 to 1910 there was a growing concern relating to the many "diploma mills" among the total of 155 medical colleges then open. Abraham Flexner (B.A. Johns Hopkins and M.A. Harvard) was commisssioned by the Carnegie Foundation for the Advancement of Teaching to survey the problems. As a result of the Flexner study wholesale closing of the worst of the schools and consolidation and reorganization of many of the remaining ones resulted in greatly improved knowledge possessed by medical graduates as the first third of the century ended.

In the second third of the 20th Century, American medicine made giant strides in quality and quantity of post-graduate education and specialty training. Specialty boards with rigid requirements made carefully planned specialty training of three or more years beyond internship an absolute requirement. In this era great improvements were made in all techniques of American medicine. It was in Minneapolis that Dr. Christian Barnard learned heart surgery. The Lawrences of Berkeley and many others made this country the pioneer and leader in nuclear medicine. Many other brilliant developments occurred.

In this final third of our century we find both quantity and quality of medical knowledge in the newly graduated physician to be very high. Training opportunities of excellent caliber are abundant ranging from family practice through all the specialties. There is currently a rapid increase in the number of physicians graduating. In the past five years physicians have increased in number 2.4 times as fast as the population has increased. New medical schools have opened or are in the process of coming into being and new concepts in medical education relating to combined degree with shortened years and the Dartmouth type plan condensing the previous four years of medicine into three years all will tend to increase the supply of physicians. Despite these facts there is an impatience among concerned trustee-type citizens of Springfield and of other parts of this country. Ideas range from the mistaken notion that the AMA wishes to limit the number of physicians to the recent comment of Thomas Watson, Jr.,

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Chairman of the IBM Board: "I completely believe in the American free enterprise system but when the system clearly fails to produce a much needed good, we should not flinch from looking to some sort of government intervention to get the job done. We have only one choice before us that will work: some very new form of national health insurance."

Never in the history of our nation have so many physicians been committed for so many years to meet the needs of military service in the zone of interior and many foreign posts. This has significantly diminished the number of physicians available to render civilian patient care. Another unfortunate trend is that of premature retirement of physicians in all parts of our country and the exercise by many of their perfect right to accept positions as health service physicians for colleges, physicians with industrial plants, or physicians who guide the medical judgments of large insurance companies. This latter trend has been accelerated by the advent of Medicare, Medicaid and by other signs of our times including rapid expansion of malpractice claims.

Many of the problems of this third of our century will not be solved instantly by legislative edict. More physicians, more efficiency, more perspiration, and more optimal use of allied medical personnel is certain to be constructive than further legislation and the attendant thousands and thousands of added administrative and clerical workers in new governmental programs and bureaus.

In the third period extra effort sometimes brings victory.

John W. Turner

John W. Turner, M.D.

MMTP AT THE PROVIDENCE HOSPITAL

In November, the *Holyoke Transcript* carried a front page headline announcing that the Providence Hospital was to open a methadone maintenance clinic. The complex, controversial, and frustrating subject of drug addiction and how best to handle it was at last being extracted from the talk stage, and something positive was to be done in an attempt to curb addicts' habits.

There has been much written pro and con about the merits of a methadone maintenance treatment program. Is this form of treatment making new addicts and indulging criminals? Or, are the statistics from the pilot maintenance programs in New York reproducible? Statistically monitored by the Columbia University School of Public Health and Administrative Medicine since its inception, methadone maintenance has rolled up an impressive score, with better than an 80% success rate. As of September, 1969, 2,205 individuals had been admitted to the program. Of these, 18% dropped out. The rest remained in treatment, and after three years, only 2% had been re-arrested; 96% were in school or gainfully employed (as compared to only 28% on admission), and none had become re-addicted. These figures compare most favorably with such programs used at the Public Health Service Hospital in Lexington, Kentucky where the re-addiction rate is well over 90%.

The program which officially began on December 7 was initially conceived by Sister Marie, Immaculate Heart, Assistant Administrator of the Providence Hospital, Mrs. McInerney, Social Worker, and Mr. Dudley, Chief Pharmacist. Many months of visiting clinics in New York, Boston, and New Haven, and coordinating their plans with law enforcement authorities, mental health personnel, physicians, and hospital administrators were involved prior to the first hard core addict taking his first drink of cranberry juice with methadone. The clinic is open 7 days a week, and the patient comes 2 times a day until he is ready for 1 time a day, which is usually after a six to eight week period. Seven physicians volunteer their time daily to meet the patient and discuss any side effects or other medical problems. The physicians in the program are Drs. John Driscoll, Chief of Staff and Head Physician, Gardner Cox, Henry Burkhardt, Norman Halpern, Ralph Levin-Epstein, Michael Rosner, and Joseph Michelson. Periodically, urines are obtained and sent to a laboratory in the Boston area to determine if the patient has been taking any other drugs while he is on the methadone. If he is found to be taking other drugs, he is warned about this and may be dropped from the program if this persists.

As follow-up therapy, nine patients are beginning group therapy conducted by a staff from the Mental Health Center in Holyoke. Five others are attending the Mental Health Center on an individual

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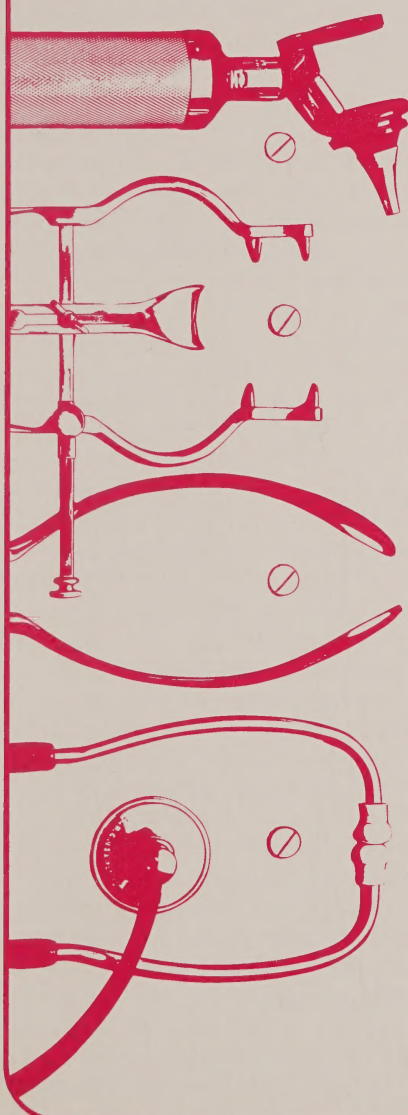

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basis. When other patients are considered to be ready, they also will be referred for follow-up therapy. Contacts with vocational rehabilitation and colleges have been made regarding two of the patients.

Weekly staff conferences are held to evaluate the patients on program, discuss questionable referrals, review and interpret results of the program, and to update statistics.

Forty applications from the Greater Holyoke-Springfield Area have been received at the present time and twenty patients are currently in the program.

The program is financed by the Providence Hospital as a community service, but they were recently granted $18,000.00 by the State Department of Mental Health which will help to defray part of the expenses.

AIMS AND OPERATION

This methadone maintenance program is basically adaptations of prototypes at the Morris Bernstein Institute, Beth Israel Medical Center, New York City; and the State of Connecticut, Department of Mental Health Program located in New Haven, with the assistance of the Yale/New Haven Hospital facilities.

In a very condensed form the program proceeds in three (3) phases. Phase I, the patient is accepted into the program only after a lengthy and confidential intake procedure by Social Services; and if necessary, the patient is referred to the Program Panel for its final decision regarding the admission of the patient to the program. The Federal Register criteria are the standards for admission and these include a documented history of abuse of one or more opiates; a confirmed history of one or more failures of withdrawal treatment, and evidence of current abuse of the opiates. It would exclude from treatment those patients who are diagnosed as psychotic, those less than 18 years of age, and those with a serious physical disease.

In Phase I the patient is given a complete physical examination and started on methadone. The dosage is administered in blockage levels in divided portions and is increased gradually until the tolerant maintenance level is reached. During the early stages of the treatment the patient visits the clinic everyday; leaves a visually supervised urine sample and takes his dose of liquid methadone by mouth in the presence of a nurse. The urine sample will be tested for opiates, amphetamines, barbiturates, methadone and quinine. Once stabilized and the maintenance level is reached the patient takes the prescribed dose of methadone once daily. The patient now proceeds into Phase II.

This phase is a period lasting about one year; the routine changes and the individual comes to the clinic weekdays only and gradually the clinic visits are reduced to three times weekly, and finally to once a week. During the intervening days the individual continues medication at home, however, this person must visit the clinic at least once a week to obtain the supply of methadone and leave a urine specimen.

Phase III begins when the patient has led a productive life for a year and has no problems with alcohol or other drugs. At this time the individual is usually employed or in school; or if a female, is managing a household. During this phase the patients need for contact with the staff personnel decreases, however, they continue to take at least one dose of methadone at the clinic each week and leave a urine sample for testing.

As a follow-up to Phase III, the next procedural step is to bring about a detoxification of methadone by gradual withdrawal over a period of time based on the patients needs and reactions. Hopefully, the person on this program by this time would be stabilized enough, by psychiatric/psychological treatment if necessary, to be able to do without drugs of the addicting type whether the drugs are of the physically and/or psychologically addicting nature.

This program is specifically designed for the established opiate addict and its objectives are to place this person "on the road" toward rehabilitation and to

transfer the addict into a functioning and contributing member of society. This type of program does offer the hard-core opiate addict an alternative to the previous anti-social pattern of living, and a chance for a new life.

In regards to the selection of the patient the MMTP has proved effective in the management of the chronic addict who has failed other treatments and who has volunteered for methadone therapy. It is not recommended for the occasional user of narcotics, or for those with a short history of dependence; with such people the effort should be made to cure the addiction by more conventional means, such as individual or group psychotherapy.

Investigation has shown that the majority of new patients need no in-patient admission; if an in-patient stay is necessary, the patient is admitted as a medical problem. By regarding the opiate addict as a patient suffering from a chronic metabolic disease and relieving him of his compulsive drug hunger, methadone maintenance opens the doors to a meaningful, self-sufficient life. The functioning programs have already shown that an apparently hopeless addict can be motivated to realize his innate abilities and potential. It is believed that methadone therapy now offers substantial hope for the rehabilitation for heroin and other opiate addicts. Despite the fact that it substitutes one addiction for another, many investigators are convinced that no other presently available therapy offers comparable promise for the many opiate addicts who are seeking help.

Being relieved of his opiate addiction, this person is for the first time truly amenable to rehabilitation – personal counseling on problems of everyday living – help with family problems – referral to appropriate community agencies, vocational guidance, educational assistance and, if necessary, legal services.

In regard to methadone treatment of pregnant patients on this program, our research had indicated that when methadone is administered to the pregnant patient in minimal blockage levels the child is born virtually free of drug dependency. This has been established at the Yale/New Haven – Connecticut Department of Mental Health Program. The new-born is placed in the infants intensive care unit and is carefully observed for a period of about 2 weeks; in all cases, this far, there has been very minimal withdrawal symptoms observed, and no form of withdrawal treatment has been required for these infants.

It is apparent that methadone has proved highly effective in the treatment of opiate addiction, but it is still unavailable to most addicts. Providence Hospital feels it is fulfilling a much needed service in this area by instituting such a treatment program; even though it realizes this is not a total answer to a problem of such magnitude, however, it has decided to grasp onto this amorphous problem and to start a workable program for this area.

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ARE THEY READY?

Professor William J. Curran, a legal medical expert at Harvard University, has taken a hard look at health planning agencies from the legal viewpoint. Writing in *Health Planning Perspectives,* Professor Curran titles his article "Are Planning Agencies Ready for Community Decision-Making Roles?" He thinks not!

He questions what they are destined to become, and asks "will they develop as *partners* of other health and social agencies in the effort to achieve better health, or will they become *judges* and *regulators* of these same community forces?"

Further:

"1. Are these health planning agencies ready to take on the task of community decision-making, and will such obligations be compatible with other program activities and objectives?
2. Are these agencies and their citizen-provider boards technically trained and equipped to conduct fair and equitable reviews and hearings and to make decisions in such individual cases?
3. Are these agencies operating on clear and firm legal foundations, and are they publicly accountable to their communities for their actions?"

Professor Curran predicts that health planning agencies will become governmental decision-makers, and believes that in deciding matters important to the community they must be equipped in techniques of individual case adjudication and have a sensitivity to legal rights and obligations. As they are now organized he does not believe they are so equipped, and feels that they will require legal professionals with knowledge and skill in the adjudicatory and regulatory processes. He is concerned about this governmental role, and points out the inconsistency that most of them have been organized as voluntary, private, non-profit corporations, financed by law half from federal grants and half from community contributions. He is most concerned as to their ligitimacy and their accountability, and urges that the states take steps to place them on a firm legal foundation and that legal measures be enacted to provide that they are accountable to the people of their communities.

It seems urgent that the legal status and authority of health planning agencies be soon clearly defined. It seems equally urgent that additional legal and medical professionals must be involved if programs are to succeed and goals are to be reached.

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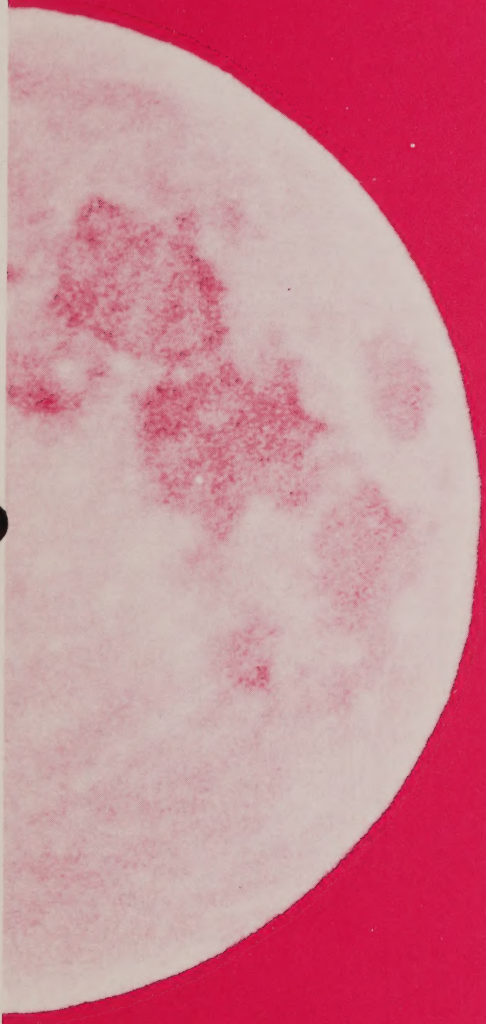

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GEOGRAPHICAL AREAS AND BLUE SHIELD FEE PAYMENTS

With increasing pressure from those outside of the medical profession for controls on physicians' fees and insistence on the part of the Social Security Administration that under the law fees for Medicare must be broken down on geographical areas as a form of control, the Mass. Blue Shield undertook a geographic and specialty analysis of physicians' fees in Mass. as reported to it during the calendar year of 1969. Forty surgical and 8 medical procedures were analyzed with the following recommendations resulting therefrom.

"Based upon this analysis, it is recommended that Usual and Customary Profiles be based upon two (2) specialty-groupings for surgical procedures: GPs and Family Practice, and all other specialists. For medical services, it is further recommended that Usual and Customary be based upon 28 specialty groupings: each separate specialty to be treated separately. For both medical and surgical services, it is recommended that the Commonwealth of Massachusetts be broken down into two (2) areas. Area I should comprise of the following Standard Metropolitan Statistical Areas (SMSA); Boston, Brockton, Springfield, Worcester, and Pittsfield. Area II should consist of the rest of the state comprising of; Providence-Fall River, New Bedford, Lawrence, Lowell, Fitchburg and the Rural area."

The leadership of Blue Shield points out that actually 4 varying geographical areas of charges as submitted by Mass. physicians are noted with the differences between the upper two and the lower two not being overly significant so that two geographical areas can be justified for approval to the SSA for Medicare. It is also pointed out that MMS's own consulting firm's – Arthur D. Little, Inc.

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– findings substantiate these geographical differences in fees. Moreover, since it would be difficult to defend paying for physician services on two different bases in Mass. – one for Medicare and another for Blue Shield, the Central Professional Service Committee of the Mass. Blue Shield at its meeting of January 6, 1971, accepted and voted the above quoted recommendations as policy for Medicare and its own usual and customary fee program.

The data on physicians' charges as submitted is going to be analyzed each year so that not only may the limits be changed within a region, but the area included in a region might also change. "Gerrymandering" can ensue by shifting and influencing of physicians' choices of where to practice as well as "testing the top" by submitting higher charges so as to be included in a prime region.

A note of comfort has been hopefully interjected to the effect that most physicians' fees are below the limits set within each of the regional and specialty groupings and that only physicians in the upper ranges of charges would be affected. Moreover, although the groupings are established by such an analysis, this does not automatically mean that an individual physician in a lower region is going to be paid less than an individual physician in a prime area.

It might be emphasized at this point that inspite of MMS Council and Executive Committee action, Mass. Blue Shield policy is set by the latter's Board of Directors and in this case by the latter's subcommittee – the Central Professional Service Committee. Who runs Blue Shield? Not the Mass. Medical Society!

Ayres

ATTENTION COMMITTEE CHAIRMEN!

Committee reports that are purely informational in character need not be presented at the Annual Meeting. Instead, they will be published in the April issue of the *Hippocrat.*

The only requirements are: (1) that the report not exceed 300 words and (2) that the original report and a copy reach the Society's headquarters not later than March 9. A copy of the report is necessary for printing in the *Hippocrat.*

Reports containing "recommendations" will have to be presented at the Annual Meeting.

Chairmen of sub-committees are not expected to present reports at the Annual Meeting; rather, they are to report to their respective parent committees.

Your cooperation is urgently requested.

Setrag A. Zacarian, M.D.

Setrag A. Zacarian, M.D., Secretary

Ernest A. Byron, Jr.

* * * * * *

SPRINGFIELD

In Memoriam

MARIO J. CARIANI, M.D.

1898 - 1971

Dr. Mario J. Cariani of 280 Williams Street, Longmeadow, died at the Mercy Hospital on January 14, 1971.

Born in Springfield, Mass., on December 26, 1898, Dr. Cariani attended local schools and went on to receive a B.S. degree from Fordham University, New York in 1919 and his doctorate in medicine from Tufts Medical School in 1924. After completing an internship at the Wesson Memorial Hospital, he engaged in the general practice of medicine in Springfield until 3 years ago when he retired.

Dr. Cariani served for many years on the medical staffs of the Wesson Memorial Hospital and the Mercy Hospital. He was a member of the AMA, MMS, HDMS and the Springfield Academy of Medicine.

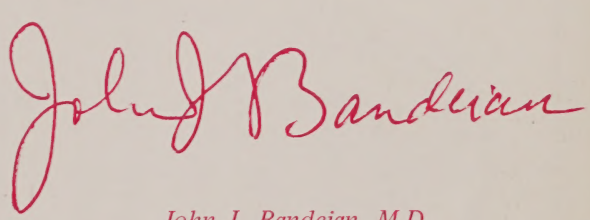
Deepest sympathy is hereby extended to his family and to his many friends and associates.

YOUR COMMITTEE OF CHOICE

In order to insure the widest possible participation in the H.D.M.S.'s affairs, I am hereby inviting and urging members who have a particular interest to name the committee on which they would like to serve. Needless to say, the effectiveness of a committee is in direct proportion to the interest and concern of its members.

In the forepart of the *Hippocrat* is a complete listing of the Society's committees. Simply by dropping a note or calling the H.D.M.S. office at 1414 State St., Springfield, Mass. 01109, your interest and preference will be given most serious consideration for appointment. Moreover, you will be rendering a distinct service to your profession, your community, and your Society.

Committee work is the heart of any organization. I urge you to let us know where you wish to apply your talents and energies.



John J. Bandeian, M.D.
Vice President and President-Elect

LICENSURE OF ALLIED HEALTH PERSONNEL

"The American doctor is almost flat on his back, staggering under an unprecedented patient load. The only quick way to get him back on his feet is to give him some extra hands." So stated Dr. Walter C. Bornemeier, President of the AMA, in suggesting the use of physicians' assistants to help meet the ever increasing demand for health services. These physicians' assistants would not be licensed physicians, but would carry out many routine chores under supervision, thereby freeing full-fledged physicians to see more patients and concern themselves with the more technical aspects of diagnosis and treatment. Obviously, we need more doctors, and existing medical schools are encouraged to expand while new ones are being formed. Nevertheless, the demand has been increasing faster than the supply for a variety of reasons. Not all medical graduates are directly involved with patient care, as many turn to teaching, research, or industry. Furthermore, the growth of third-party payment plans, and especially government involvement in medicine in Medicare, Medicaid and other programs have further increased the demand for physician services. In addition, a better educated, better informed citizenry has become more health conscious and seeks physicians' services more than did their forebears.

To meet this growing demand, we must not alone turn to physicians' assistants, but we must turn more and more to a variety of paramedical personnel, or "allied" health workers as the AMA prefers to call them. We turn to nurse practitioners, intravenous technicians, surgical technicians, physical therapists and their assistants, occupational therapists and their assistants, medical laboratory technicians, inhalation therapy technicians, psychiatric technicians, pediatric associates, radiologic technicians, and many others. It is estimated that more then 200 such health occupations now exist, and that by 1975, there will be 20 to 25 supportive personnel for each physician.

The need for more workers in the allied health fields cannot be disputed as the overburdened physicians seek to satisfy the ever increasing demand for health care. Yet it must be recognized that the delegation pf physicians' tasks to allied medical personnel is not without risk. Standards of education and training

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must be setup to insure good patient care. On this issue there is no disagreement. The question is how the standards should be setup, by whom, what standards there shall be, and how they shall be enforced. Solutions to these questions are less obvious.

Meanwhile, the ever growing list of health occupations previously referred to has produced more specialization among these health workers than in medicine itself. Such specialization is not always advantageous. The restrictions in areas of practice imposed on these workers by specialization result in loss of job flexibility and aggravation of the manpower shortage. Furthermore, workers in a narrow health field customarily form an association to gain recognition, and perhaps economic advantages. Subsequently, educational standards are established, clinical or apprenticeship experience may be required, and accreditation is sought. The next step is seeking state licensure.

The growth of such licensure is increasing at a fantastic rate. *State Licensing of Health Organizations,* a public health publication, reported in 1967 that there are 25 health occupations regulated by a total of 794 statutes in various states, and many more licensure bills are pending in various state legislatures.

NOT THE ANSWER

However laudable elevation of educational standards may appear, licensure is no assurance of competence. The best example of this is the licensure of chiropractors, an unscientific cult that the General Court in one of its least enlightened moments saw fit to license, and the uninformed patient believes he is in the hands of a trained physician. Certainly there is a need for certain formal educational requirements and clinical experience which licensure is assumed to require, but licensure may well create more problems than it solves. Because licensure laws purport to identify the areas of practice permitted, there may be such restriction of permitted tasks as to either require more personnel or multiple licenses. Furthermore, by controlling the number of individuals entering a given health occupation, licensure increases the status of these occupations with resulting increased costs. Limitations are imposed on health workers, so that it may sometimes be difficult to determine who should carry out a given task. These limitations may not alone aggravate the manpower shortage, but they operate to the disadvantage of the health worker. For example, education and examination requirements may prevent a licensed practical nurse who has had formal training and long hospital experience from advancing herself to becoming a registered nurse.

The House of Delegates of the AMA at its recent meeting in Boston, November 29, to December 2, 1970, recognized the need for a more discriminating terminology for all types of health

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occupations. The House went further and pointed out the need for identifying the degree of independence and professional skill to be required by allied health workers at each level. At the same time, in approving Report E of the Board of Trustees, the House cited a growing opinion that quality health care cannot be assured by occupational licensure. Furthermore, the proliferation of mandatory occupational licensure laws tends to foster a "craft union" approach to health care and leads to unwarranted increases in costs of service. In addition, the feeling was expressed that current occupational licensure laws may inhibit innovation in education and use of allied health aids. At the same time, licensure does not protect physicians or hospitals from liability stemming from the activities of these workers.

Solutions to these problems are not easily available, but licensure is definitely not the answer. The Council on Health Manpower of the AMA's Board of Trustees recommends that state legislators amend state medical practice acts to remove any barriers to increased delegation of tasks to allied health personnel by physicians. The Council furthermore suggested that a study be made to establish educational requirements and job performance tests as alternatives to licensure or certification of health personnel. Encouragement of programs to update knowledge and skills of currently licensed or certified occupations was also recommended.

APPROACHES

To expedite delegation of tasks by physicians to allied health workers, the report suggests an amendment to state medical practice acts suggesting a statement such as "Nothing in this article shall be so construed as to prohibit service rendered by a physician's trained assistant, a registered nurse, or a licensed practical nurse, if such service is rendered under supervision, control and responsibility of a licensed physician." "Direct supervision" appeared in the original wording, but it is interesting that

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the word "direct" was deleted so that the physician need not *personally* supervise an allied worker to whom he has delegated certain responsibilities.

A "physician's assistant" was defined by the "House" as " . . . a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant".

The American Hospital Association has a Special Committee On Licensure Of Health Personnel that is now studying the problem further. Meanwhile, that committee recommends a nationwide moratorium on additional licensures of categories of health personnel and the establishment of a national task force to improve licensure practices. A voluntary certifying body was suggested to look at job related groups of health occupations and to determine minimal qualifications, perhaps with federal governmental guidelines for these qualifications.

At the same time, the National Commission on Accrediting will study health professions' accreditation, concentrating on programs examined by the AMA's Council on Education. The Commission indicated that the relationship of accreditation to licensure certification and registration, and its effects on the availability of health care manpower will be studied with the AMA Council on Education and the Association of Schools of Allied Health Professions acting as co-sponsors. William K. Selden, former NCA Executive Director will direct this study. Among the problems to be resolved are (1) to whom should accrediting bodies be accountable, (2) their structure, (3) expansion of accrediting responsibilities, and (4) financial problems. It is hoped that from this study a universal program will evolve.

There is no doubt that physicians very much need the services of allied health workers. The problem is in insuring competence by these workers without being boxed-in by inflexible laws of licensure. As long as the physician must accept the responsibility for the work of health workers, and he must, it should be the physician who determines what tasks may properly be delegated to a health worker, rather than having these tasks restricted by the rigidity of licensing requirements. Hopefully, these studies in progress will bring us some answers.

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One Man's Opinion . . .

MEDICAL READER

"As a stream cannot rise above its source, so a code cannot change a low-grade man into a high-grade doctor, but it can help a good man to be a better man and a more enlightened doctor. It can quicken and inform a conscience, but not create one."
— International Code of Medical Ethics, World Medical Association, 1949

Mrs. Lund of the Springfield Academy of Medicine was kind enough to call attention to a new book recently acquired by the Academy Library. Its title, *The Patient As Person* (1) fairly well reflects its contents, but its subtitle reveals even more. It reads: *Exploration In Medical Ethics.* To this, the word "Modern" might well be added because the book deals almost exclusively with the newer and more current ethical problems confronting our profession today.

The author, theologian Paul Ramsey, is Professor of Religion at Princeton. He was for two semesters the Joseph P. Kennedy, Jr., Foundation visiting professor of genetic ethics at Georgetown University Medical School. He is the author of a number of books dealing with religion, morality and ethics.

The book, we learn at the very beginning, is based on the Lyman Beecher Lectures on Medical Ethics delivered by Professor Ramsey at Yale University in April, 1969. The major topics covered in this volume include: (a) the meaning of consent in human experimentation, especially with children; (b) improving procedures for determining when a man has died; (c) the limits upon caring for the dying with the new technologies of life preservation; (d) the morality of donating vital organs; (e) heart transplantation as an experimental treatment; (f) whether we should give or take cadaver organs; and (g) the problem of choosing among patients to receive scarce and vital treatment, such as renal dialysis. Topics, such as abortion and genetic control are conspicuous by their absence. This would seem to indicate that the author had no intention of covering the subject of medical ethics in its entirety.

The Patient As Person is not the kind of a book that everybody could agree implicity with everything in it. Such is

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the nature of the philosophy of ethics. It often raises more questions than can be answered. But the questions must be raised and Professor Ramsey does it admirably.

The book is scholarly, yet pleasantly readable. It is critical yet constructive. Its numerous annotations, footnotes and bibliographical references in themselves make its reading worthwhile. These references direct us to numerous articles in medical journals and also to a number of books exploring the subject of medical ethics. Notable among these are: *Ethics in the New Medicine* (Dr. Francis Moore); *Medical Research and the Individual* (Dr. Henry K. Beecher); and *Ethics in Medical Progress* (Dr. G.E.W. Wolstenholme).

The Patient As Person should be hailed as a worthy addition to the Academy's book shelf on medical ethics.

ARE YOU A PHILATELIST?

Stamp collectors will find *Medicine on Stamps* (2) a most fascinating book. Written by Joseph H. Kler, M.D., it offers a visual record of the history of medicine.

Dr. Kler, a practicing EENT specialist in New Jersey, compiled an extraordinary collection of *Medicine on Stamps.* It consists of over 16,000 stamps in 44 volumes, which he has donated to the Cardinal Spellman Philatelic Museum at Regis College, of which he is a founder.

Medicine on Stamps presents the highlights of this gigantic collection. In addition to the usual illustrations of the actual stamps, it provides biographical vignettes of the physicians commemorated. Thus we learn that Walter Reed received his medical degree before the age of 18, (the youngest medical graduate in the U.S.A.) and that among the signers of the *Declaration of Independence* there were no less than five physicians. And did you know that William H. Harrison was the only President of the U.S. to study medicine in a formal way? Unfortunately, he never completed his studies.

NATIVE SON MAKES GOOD

Coming closer to home it is interesting to note that a native of Holyoke recently made literary headlines. He is William A. Nolen, M.D., whose book, *The Making of a Surgeon,* has reached some of the best-seller lists. Dr. Nolen spent his youth between Holyoke and South Hadley. He is a graduate of Holy Cross College and Tufts Medical School. He is now a practicing surgeon in Litchfield, Minn. His grandmother still lives in Holyoke.

(1)The Patient As Person. By Paul Ramsey, 283 pages. Yale University Press. 1970

(2)Medicine on Stamps. By Joseph H. Kler, M.D. Minkus Publications, Inc., New York. 1969

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HIGHLIGHTS OF THE JANUARY EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday evening, January 19, 1971, in the Conference Room of HDMS.

The meeting was called to order by President Turner at 8:10 P.M.

Present were Drs. Turner, Bandeian, Zacarian, Goldberg, McHugh, Cummings, Kelly, Fisher, Sullivan, Mozden, Moore, and Mrs. Purdy.

The minutes of the December meeting were read and approved by the Committee.

CORRESPONDENCE

A "thank you" letter from Mrs. Galuszka was read in answer to a sympathy letter sent to her at the time of Dr. Galuszka's death. Mr. Devine, Administrator of the Wesson Women's Hospital, wrote telling about the many activities that Dr. Galuszka had participated in at that hospital.

OLD BUSINESS

Dr. Sullivan gave a brief report of the advanced ambulance system training program with its past history and present status. A letter had been received from Mr. Bott, Associate Executive Director of the Springfield Hospital Medical Center, informing the Medical Society that the grant for this had been lost since there was a lack of interest on the part of the Police Departments. Hopefully in the future this program or a similar one will be held.

Dr. Turner gave a report on the all-day seminar held at the Girl's Club for Model Cities. This meeting was held with state agencies representing health, education and welfare, and others on the health planning for the Model Cities Area.

Dr. Ellison, a local dentist, is interested in forming a local committee to do Dental Health Education with particular emphasis on the benefits of fluoridation. He would like the endorsement and support of the HDMS and suggested the following names to serve:

Dr. Sheffield – the Medical Society's representative to the Model Cities Area.

Dr. John W. Turner – President of the HDMS.

Dr. Robert Sears – Chairman of the Public Health Committee.

Dr. Bernard Gilchriest – Chairman of the Public Relations Committee and his committee.

Mrs. Vivian M. Purdy – Executive Secretary of HDMS.

The Executive Committee also

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suggested adding Dr. Dalton Kinsella and Dr. John C. Ayres.

Dr. James Allan, Legislative Chairman, wrote telling about a resolution that has been submitted by him to Senator Hammond and Representative Farnsworth. He also requested that another resolution, submitted last year by HDMS to MMS, be resubmitted again to them for consideration, with the addition of "Chapter 176B". The motion was made, seconded and passed that this be resubmitted to MMS.

NEW BUSINESS

A letter from the Department of Public Health, Division of Sanatoria and Tuberculosis Control, has been enclosed with the *Newsletter* to the membership.

A physician has complained about a pamphlet known as "Drug Utilization and Drug Utilization Review" published by Public Health Service under HEW. This has been referred to the AMA for comment. The AMA sent a telegram stating that an official government publication was beyond the control of the AMA Legislative Department. However, a note followed stating that the AMA Council on Drugs plans to discuss this publication with the author, Donald C. Brodie, Ph.D. at its winter meeting on January 15 and 16, 1971. A report of that meeting will be requested.

The pamphlet called "Experience Shows You Need a Family Doctor" and printed a few years ago is to be distributed by Welcome Wagons to new residents of Hampden County. It was felt that this should be updated, and it was referred to the Public Relations Committee for study.

Dr. Ayres attended the meeting to give a report of the Executive Council meeting of the MMS held on January 13, 1971 in Boston. He touched on the subjects of interest in the *Circular of Advanced Information* and brought the Committee up to date on the latest plans of Blue Shield.

The new Medico-Legal Code has been completed by the Hampden County Bar Association and the Malpractice, Medico-Legal Affairs Committee of the HDMS. It was voted that this be properly reproduced and distributed to the Committee for approval at the next Executive Committee meeting with presentation to the general membership in the near future.

Dr. Parenteau has offered to put on another musical variety show probably in the fall of 1971. The Committee voted approval of this and recommended that the Springfield Academy of Medicine be contacted for a possible joint meeting.

The meeting was adjourned at 9:45 P.M.

The Grievance Committee met and heard three cases.

The meeting was adjourned at 10:00 P.M.

MARK YOUR CALENDAR NOW!

HDMS Annual Meeting, April 27
HDMS Executive Committee Meetings, March 16 and April 20
MMS Annual Council Meeting, Boston, May 26
MMS Annual Meeting, Boston, June 1-3
American Academy of Orthopedic Surgeons, San Francisco, March 6-11
National Medicolegal Symposium, Sponsored by AMA and ABA, New York, March 18-20
American Society of Internal Medicine, Denver, March 26-28
American College of Physicians, Denver, March 28-April 2
AMA Annual Meeting, Atlantic City, June 20-24

SPRINGFIELD'S MORTALITY STATS

An unofficial analysis of death certificates filed in the City of Springfield for residents thereof in 1970 reveals that a total of 1,666 persons died therein during the year. This figure does not include those Springfield residents who died outside of the City nor the 837 deaths of non-residents occurring in the City.

TEN LEADING CAUSES OF DEATH

1. Diseases of the heart	632
2. Neoplasms	278
3. Cerebrovascular lesions	232
4. Pneumonia (all types)	119
5. Accidents	87
6. Cirrhosis of Liver	56
7. Diseases of circulatory system	54
8. Bronchitis	38
9. Diseases of early infancy (under 4 weeks of life)	45
10. Diseases of skin & cellular tissue	20
All other causes	105
	1,666

Deaths from heart disease lead the list with 37.9%; next, neoplasms with 16.7%; third, cerebrovascular lesions with 13.9%; fourth, pneumonia with 7.1%; and fifth, accidents with 5.2%. Approximately ¾ of the deaths occurred in those 60 years of age and above. Males predominated over females in the ratio of 1.07 to 1. The trend, as in the recent past, continues to point out that chronic diseases, particularly those of the cardiovascular system in the older groups are the major killers of Springfield residents.

DEATHS FROM INFECTIOUS DISEASES

Pneumonia	119
Bronchitis	38
Meningitis	2
Meningococcal Infection	1
Tuberculosis	1
Total	161

Only 4 deaths were due to infectious diseases considered officially dangerous to the public health. Most of the pneumonia and bronchitis were undoubtedly fatal precipitations superimposed on some other debilitating disease.

Analyzing the 87 deaths occurring to 47 men and 40 women as the result of accidents, the following interesting facts present themselves. First 49 or more than one-half occurred in or about the home as the result of falls involving 22 men and 27 women primarily in the older age groups. Secondly, 17 persons were killed as the result of traffic accidents – 3 drivers, 5 passengers, 5 pedestrians, 1 falling from truck as it backed up, and 3 bicyclists. Eight died of burns and 3 drowned. Two deaths occurred from heroin overdosage and 1 death respectively from narcotic overdosage, automobile crushing, hydrolic truck apparatus crushing, asphyxiation from food impaction and dental plate impaction, perforation of right ventricle, and lead poisoning.

It might be pointed out for mental health connotations that there were 17 suicides (11 male and 6 female) with deaths beginning in the twenties, peaking in the 40-60 age group, and continuing to 80 and above. Moreover, there were 12 deaths associated with homicides (7 male and 5 female).

There were no deaths resulting from complications of pregnancy, but 36 stillbirths were reported. Fifty infants (under 1 year of age) died with 45 due to prematurity, 3 due to pneumonia, and 2 due to diseases of skin and cellular tissue.

Ayres

Correspondence . . .

A NEW STANDING COMMITTEE

To the Editor:

At the December 8, 1970 meeting of the HDMS it was voted to make the Interhospital and Community Health Planning Committee a Standing Committee of the Society. Its membership is comprised of the president-elect of the medical staff of the several hospitals in the District, with the President-Elect of the HDMS as its Chairman. It is felt that these physicians would have a good grasp of the problems that may arise between members of the hospital staff, the hospitals and the community. Your District Society will in this way become involved, and perhaps, be in a position to lend its weight to the problems of its members.

In 1966 Congress passed into law PL89-749, the "Comprehensive Health Planning and Public Health Service's Amendments." There soon sprang into being throughout the country health planning councils whose function is to study the health needs and available facilities in the community and to advise both State and Federal Government concerning their findings. Congress will look to these health planning councils for advice as to how much and where medical facilities and hence Federal monies will be directed.

The Connecticut Valley Health Planning Council (soon to change its name) had its first meeting in July of 1966. In November of 1967 it obtained a charter from the Commonwealth of Massachusetts for the purpose of "providing a framework for the orderly development of health services and facilities" throughout Western Massachusetts. This council has been very active since its inception. It is funded to the extent of 49% by Federal funds. Massachusetts Department of Public Health as well as Massachusetts Blue Cross-Blue Shield have most generously helped it along. This council anticipates that in the future it will be in position to advise the Federal Government as well as the State Government where to build medical facilities, etc.

The Federal Government is intimately involved, directly or through such health planning councils with the practice of medicine. As physicians, it is our task to treat the individual patient; and as thoughtful citizens we should take part in the overall community, state and national health planning and delivery of health care. It is in the community level that the Interhospital and Community Health Planning Committee will fulfill its role.

John J. Bandeian, M.D.
HDMS Vice President and
President-Elect

ABORTION

To the Editor:

In addition to the thoughtful and

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logical editorial, and two interesting and informative articles on abortion (*Hampden Hippocrat,* Dec. 1970), may I add some further reflections.

The problem of induced abortion cannot be resolved by fiat – legal, medical or sociological, even if all of these authorities were in agreement. What is needed is a reasoned and reasonable justification of the operation, or its rejection as unjustified.

Theology has a right "to testify in court" on this issue. Theological arguments are worthy of serious consideration, and to some of us the conclusion is valid. But one need not subscribe to the metaphysical concepts of the soul and of God to reach a sound logical conclusion. A reasoned and reasonable morality can be deduced by careful consideration of the data of modern molecular biology.

Consider the earliest moment of the union of the sperm and the ovum and the resulting zygote. This combination of chromosones, genes and DNA produces a unique blueprint for another individual. Unique because "this magnetic tape of the zygote" consisting of some five billion dots (from two sources) is now capable of programming far into the future the development of another human, down to the smallest physical and mental characteristic, and all this from the very onset of life. Think of that for a few moments.

Unique also in the essential worth, dignity and equality of every human being – so beautifully phrased in the Declaration of Independence, "All men are created equal" . . . "are endowed with certain inalienable rights" . . . "among these life, liberty and the pursuit of happiness." Not just words and rhetoric this, but a clear expression of the noblest form of humanism and the answer to the philosophical problem of the relative value of human life. Can any thoughtful person really believe that the developing human being can be eliminated at any stage of its existence because of social embarrassment, because he is unwanted (shades of Hitler), or because he is one too many, or just simply inconvenient?

The abortion problem is but a small part of the general moral decline of our day. Historically such periods have occurred cyclically, and never to the advantage of the nation involved. In a similar epoch over 2000 years ago, how truly amazing was the intuitive wisdom of that ancient intellectual giant and Father of medicine whose ethical convictions led him to say "I will not aid a woman to procure an abortion."

F. F. Fortin, M.D.
140 Chestnut St.
Springfield

LYMPHOMA SYMPOSIUM

There will be a symposium on "Approaches to Lymphoma" at the Springfield Hospital Medical Center, Springfield, Massachusetts, on Wednesday, March 10, 1971, from 9:00 A.M. to 1:00 P.M. Guest speakers will be Vincent DeVita, M.D., (National Institute of Health); Ralph Johnson, M.D., (National Institute of Health); Arnold Mittelman, M.D., (Roswell Park Memorial Institute); and William Maloney, M.D., (Peter Bent Brigham Hospital). No registration is required.

Further information can be obtained from Paul Friedmann, M.D., Springfield Hospital Medical Center.

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